Expanding Community-based Access to Injectables: Initiatives in Selected sub-Saharan African Countries

The provision of injectable contraception by community-based distribution agents is a feasible, safe, and effective means to increase access to contraception among underserved populations. Pilot projects and scale up efforts have occurred in several African countries including Guinea, Kenya, Madagascar, Malawi, Nigeria, Rwanda, Senegal, Tanzania, Togo and Zambia. Afghanistan, Bangladesh, Bolivia, Guatemala, Peru, Nepal and Pakistan are among the countries outside of Africa that have community-based access to injectables (CBA2I) programs. The summaries below provide an overview of CBA2I initiatives and policy status in select countries with links to documents containing additional information.

Guinea

Ministry of Health supported CBA2I pilot in 2012 that trained 15 community health workers to provide DMPA and 30 facility-based providers to address side-effects for a CBA2I pilot (March-July 2012). Since the pilot, the Ministry of Health (MOH) has changed policy to support CBA2I and endorsed the practice as part of the community package of services MOH supports.

Kenya

Based on the findings of the successful pilot conducted in the Eastern Province in 2009-2010, the Kenyan Ministries of Health adopted a new policy to allows trained community health workers to provide injectable contraceptives in areas of the country where access to contraceptives is limited. This policy change took place in 2012.

Madagascar

As of 2006, Madagascar’s guidelines allow community health workers to provide injectables. Since CBA2I was piloted in 2007, the program has been scaled up to 24 additional districts.

Malawi

As of 2008, Malawi’s guidelines permit Health Surveillance Assistants (HSAs) to provide injectables. In 2009, HSAs began providing the injectable, Depo Provera, in nine pilot districts, following a feasibility study by the Health Policy Initiative. An evaluation demonstrated that the provision of Depo Provera by HSAs was safe, acceptable, and expanded access by attracting clients to family planning.

Nigeria

Nigeria’s guidelines allow provision of injectables by Senior Community Health Extension Workers (CHEWs) in clinics. A pilot project completed in 2010 demonstrated a significantly higher uptake of injectables by clients from community-based compared to facility-based provision and showed that CHEWs can safely administer injections and dispose of wastes.
In late 2011 advocacy activities to change policy began and plans are underway to scale-up CBA2I in one state. The potential for national scale-up in Nigeria is great as there are existing CBD programs in place in many rural areas and public-sector.

**Rwanda**
The Rwanda Ministry of Health is rolling-out a phased approach to scale up community-based family planning, including injectables. Under the National Guidelines on Community Based Distribution of Family Planning, community health workers are allowed to administer injectable contraception to women who receive their first injection at a health center. Approximately 10,000 community health workers have been trained and are working in 20 out of Rwanda’s 30 districts.

**Senegal**
The Senegal Ministry of Health, Directorate of Reproductive Health, implemented a CBA2I pilot in 2012 building on the CBD of pills project completed in 2010. Under the revised National Reproductive Health policy, norms and procedure document (PNP) community health workers, called agents de santé communautaire and matrons, are allowed to administer injectable contraception. The results from the CBA2I pilot study will be disseminated in May 2013, at which time planning for scale-up of CBA2I will begin.

**Tanzania**
Tanzania’s recently-launched National Family Planning Costed Implementation Program includes an objective to strengthen the country’s community-based distribution program and expand access to family planning methods, including injectables, via drug shops.

**Togo**
In April 2011, the Togo MOH launched CBA2I pilot in two districts, covering 158 hard to reach villages, as part of an integrated community-based health program. Approximately 474 CHWs were trained, supplied with the essential equipment and supplies to conduct their FP work, and given a bicycle. Since this pilot, CBA2I has been replicated in three other districts.

**Uganda**
CBA2I in Uganda began in 2004 with a pilot. Within three years, the community-based distribution of injectables program was replicated in six additional districts by both public- and private-sector partners. In February 2011, the Ministry of Health signed into policy an addendum to Uganda’s National Policy Guidelines and Service Standards for Sexual and Reproductive Health in support of CBA2I. Nine districts are currently implementing CBA2I. With the policy amendment and the development of national public health sector Village Health Teams, the potential for scale up of CBA2I in Uganda is great. Currently, the MoH and partners are collaborating to execute a national scale-up plan for CBA2I.

**Zambia**
A CBA2I pilot was completed in February 2011, with positive results. Following the dissemination of findings, the Ministry of Health permitted the provision of DMPA by CBD
agents in the pilot sites to continue without interruption, and scale up is taking place within the pilot districts and one additional district; approximately 72 new CBD agents in 3 districts. These CBD agents joined the 40 agents already providing DMPA in their communities. The MOH is currently developing a national scale up plan and is engaged in policy change dialogue following a local study tour and a study tour to Rwanda in September 2012.